Life Insurance Application (Short Form)

Fidelity & Guaranty Life INSURANCE COMPANY

RECEIVED 2005 JUL

PROPOSED INSURED

Name (First, M.I., Last) Burtron L. Cleveland		Mailing Address 5561 E Shades Valley Dr.	
Home Telephone No. (334) 288-2098	Birth Date 8-16-1972	Birth Place (State or Country) Alabama	Social Security No. or Tax I.D. No. 420-21-3306

Height	Weight	Marital Status	Sex	U.S. Citizen	If no, give immigration status/type of visa:
5'7"	170lb	[x] Single [ ] Married [ ] Divorced [ ] Widowed	[x] Male [ ] Female	[x] Yes [ ] No	

Occupation, Duties, and Annual Income from Employment: Self Employed (Clothing Salesman) $25,000.

BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED *(Unless otherwise noted, the beneficiary of other persons proposed for coverage will be the proposed insured.)*

Primary	Contingent
Bobbie Cleveland (mother)	Rahiel A. Cleveland (Brother)

OWNER(S) *(Unless otherwise noted, the Owner will be the Insured. For Florida applicants, you may name a secondary addressee to receive notice of possible lapse in coverage - complete the Additional Information section.)*

Name Bobbie Cleveland	Relationship to Proposed Insured mother	Social Security No. or Tax I.D. No. 423-81-3983
Address 5561 E. Shades Valley Dr.	Birth Date 9-4-1955	Telephone Number (include area code) (334) 288-2098

POLICY INFORMATION

Plan of Insurance: Home Certain without money back	Amount of Insurance $100,000	Initial Premium $31.68	[ ] Nontobacco [x] Tobacco
Planned Premium $31.68	Term Plan: Number of years *(term period)* 20 yrs	Universal Life:	[ ] Nontobacco [ ] Tobacco

Mode of Payment *(For bank draft, complete Check-O-Matic authorization, and initial payment required.)*
[x] Monthly Bank Draft [ ] Annual [ ] Bi-Weekly Bank Draft [ ] Other:

Total Amount Paid in Exchange for Receipt $31.68

(No coverage will be effective except in accordance with the terms of the Receipt and unless full initial modal premium payment is submitted.)

ADDITIONAL BENEFITS (availability varies)

- [ ] Disability Income Rider – Class ______
  Monthly Payout $______
  - [ ] 3 mo. Elimination, 2 year benefit
  - [ ] 6 mo. Elimination, 5 year benefit
- [ ] Waiver of Premium Rider (term only)
- [ ] Waiver of Monthly Deduction Rider (UL only)
- [x] Child Rider – Amount 10,000 (fill out table below)
- [ ] Accidental Death Benefit Coverage Amount $______
- [ ] Other: ______
- [ ] Other: ______
- [ ] Other: ______
- [ ] Other Insured Rider (fill out table below)
  (for term products, term period of rider will match policy)
  (for UL products, enter term period: ______ years)
  Amount Chosen: $______
- [x] Return of Premium Rider
- [x] Accelerated Benefit Rider (Have you received and reviewed the accelerated benefit disclosures? [ ] Yes [ ] No)
- [ ] Critical Illness Rider (Have you received and reviewed the accelerated benefit disclosures? [ ] Yes [ ] No)
  Amount Chosen: $______
- [ ] Ultimate Income Option – Initial Lump Sum $______
  Monthly Income of $______ for ______ years, Final Lump Sum $______

Name of Other Proposed Insured(s)	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance

INSURANCE IN FORCE *(Indicate Amounts)*

Company	Life Insurance	Accidental Death Benefit	Disability Income

PERSONAL PHYSICIAN (S)

Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Results
Burtron Cleveland	Dr. Myles Chandler Primed	5-12-2002 Had check up Results OK

EXHIBIT "B"

Life Insurance Application (Short Form)

Fidelity & Guaranty Life
INSURANCE COMPANY

INSTRUCTIONS

- Fill out and sign the front and back of the life insurance application and send it to F&G Life.
  - Under plan of insurance, carefully write the marketing name of the plan of insurance. For example, "HomeCertain" is acceptable, whereas "mortgage term" or "term" is insufficient.
  - Remember to fill out the replacement question in the Agent Certification section.
  - Remember to fill out the complete addresses and phone numbers for all doctors and hospitals.
  - Remember to fill in the beneficiary's full name and relationship to the proposed insured.
  - Make sure the ZIP code is included in the proposed insured's mailing address.
- If additional space is needed or if the proposed insured or owner lives in a state where one of the fraud warnings applies, fill out and sign the overflow page and send it to F&G Life. Otherwise, discard it.
- If there is more than one proposed insured, explain any "yes" answers in the "Additional Information" section.
- For bank draft payment modes, fill out the "Bank Draft Plan: EFT Premium Authorization to My Bank" section. Attach a voided check or deposit slip and send it to F&G Life.
- If cash is paid with the application, fill out the Life Insurance Conditional Receipt stub and leave it with the applicant. Otherwise, discard it.
- Leave the stub containing the Investigative Consumer Report Pre-Notification and the MIB Pre-Notification with the applicant.
- For Corporate/Business Proposed Insureds, fill out the Life Financial Supplement form, FGLI2822.

COMPLETE THE FOLLOWING *For YES answers, give full details in the space below.*

1. Will the insurance applied for replace or change any existing insurance or annuities? *(If yes, submit replacement forms.)* ○ Yes ⦸ No
2. Does any person proposed to be insured have any other health, disability, or life insurance pending? ○ Yes ⦸ No
3. Has any person proposed to be insured been declined, postponed, or offered a rated or modified life insurance policy or been denied reinstatement? ○ Yes ⦸ No
4. Within the past 5 years, has any person proposed to be insured had citations or convictions for motor vehicle moving violations or had a driver's license suspended or revoked? *(If yes, provide state and drivers license number below.)* ○ Yes ⦸ No
5. Within the past 2 years, has any person proposed to be insured:
   a. Taken part in any type of racing, or in mountain climbing, sky diving, scuba diving, hang gliding, or plan to? ○ Yes ⦸ No
   b. Flown other than as a passenger, or plan to? *(If yes, complete Aviation Supplement.)* ○ Yes ⦸ No
   c. Any foreign residence or travel contemplated? ○ Yes ⦸ No
6. Has any person proposed to be insured used tobacco in any form:
   a. within the past 12 months? *(If yes, specify type and date last used in the area below.)* ○ Yes ⦸ No
   b. within the past 5 years? *(If yes, specify type and date last used in the area below.)* ○ Yes ⦸ No
7. Within the past 10 years, has any person proposed to be insured been treated for or diagnosed by a physician or other health care professional as having: *(If Yes, circle applicable condition.)*
   a. Any disorder or disease of the blood or circulatory system (such as: heart disease, palpitations, rheumatic fever, heart murmur, angina or chest pain, high blood pressure, stroke, anemia), respiratory system (such as: emphysema, tuberculosis, asthma, bronchitis), brain or nervous system (such as: convulsions, epilepsy, fainting spells, mental illness, or Alzheimer's disease), urinary tract (such as: kidney or bladder), reproductive system, stomach, intestines, liver, or gallbladder (such as: ulcer, colitis), endocrine system (such as: diabetes, thyroid), or muscles or bones (such as: arthritis, gout, back problems)? ○ Yes ⦸ No
   b. Cancer, cyst, or tumor? ○ Yes ⦸ No
   c. Use of barbiturates, narcotics, excitants, or hallucinogens, except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? ○ Yes ⦸ No
   d. Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or positive test results indicating the presence of the AIDS virus? ○ Yes ⦸ No
8. Within the past 5 years, has any person proposed to be insured:
   a. Been in a hospital, clinic, sanatorium, or other medical facility for operation or advised to have surgery, observation, or treatment, seen a doctor, or been advised to and not done so? ○ Yes ⦸ No
   b. Had electrocardiogram, X-ray, or other diagnostic tests, or been advised to and not done so? ○ Yes ⦸ No
   c. Been or is now disabled, or had or now have any other mental or physical disorder not listed? ○ Yes ⦸ No
   d. Made a claim for disability compensation for sickness or injury? ○ Yes ⦸ No

Additional Information. *Explain all "yes" answers below.*

Question Number	Name of Proposed Insured	Details *(Diagnosis, Dates, Durations)*	Medical Facilities and Physicians *(Names, Addresses, Phone Numbers)*

AUTHORIZATION

I have read the questions and answers on this application. The statements made in this application are: complete; true; and correctly recorded. I **agree that: a copy of this application will form a part of any policy issued; and that no agent can pass on insurability or modify any policy issued by the Company. I also agree that, except as provided in this application's Receipt, if issued, no insurance will take effect unless and until both of the following conditions are satisfied during each proposed insured's lifetime and while each proposed insured's health is as stated in this application: (1) this policy is delivered to and accepted by the Owner; and (2) the full initial premium for the mode of payment chosen is paid at our Home Office.** I acknowledge that I have received, read and understand the notices required by: the Medical Information Bureau, Inc.; and the Federal Fair Credit Reporting Act regarding investigative consumer reports.

In order to evaluate my application for life insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, the Veterans Administration or other medical or medically-related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency and my employer to give to Fidelity and Guaranty Life Insurance Company, its reinsurers, or other designee, medical and other information which may be pertinent to the evaluation regarding me or any member of my family who is applying for life insurance.

I also authorize Fidelity and Guaranty Life Insurance Company to obtain an investigative consumer report on me or on any member of my family who is also applying for life insurance. I understand that I am entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I can reasonably be contacted during normal business hours. *Check if interview requested:* ○

This Authorization will be valid from the date signed for a period of 30 months; a photographic copy of this Authorization will be as valid as the original; I, or any of our representatives are entitled to receive a copy of this Authorization.

Certification: Under the penalties of perjury, I certify that my Social Security or Tax Identification Numbers provided on this form are true, correct and complete.

Signed at (City and State) on (Date) Montgomery AL 6-15-2003	Signature of Proposed Insured age 15 or more [signature]
Signature(s) of Additional Insured(s) age 15 or more	Signature of Owner(s) *(if not the Proposed Insured or if Proposed Insured is less than age 18)*

AGENT CERTIFICATION

(1) I have asked the questions contained in this application of the Proposed Insured(s) and Owner and duly recorded the answers; (2) to the best of my knowledge there is nothing affecting the insurability of any persons proposed for insurance as stated in this application; (3) if the initial premium was paid with the application, I have remitted it to the Company and delivered a Conditional Receipt to the Owner; (4) if Disclosure Statements are required by the state, I have given them to the applicant; (5) I have witnessed the signatures on this application.

(6) To the best of my knowledge, this application ○ **does replace** ○ **does not replace existing life insurance or annuities.**

Signature of Agent [signature]	Print Agent's Name Apvertis Dixon	Date 6-15-2003	Agent Number 000127829
License Number *(Florida only)*	Phone No. (334) 538-4300	Agent's Fax No. (334) 280-2454	Agent's E-mail Address

Complete and sign this page if additional space is needed or if the proposed insured or owner lives in a state where one of the fraud warnings applies.

ADDITIONAL INFORMATION

Proposed Insured's Name: Beatrice Cleveland (Name of Children) on Child Rider

If additional space is needed to expand on any section, please use the space below.

Section	Question	Detail
		Jamari Rollins - 9-18-1991 age 12 Sept m
		ZSANIQUE Simpson 12-1-2001 age 2 Female
		Jonathan T DM Cleveland 4-27-1998 m
		Broderick Jackson 5-27-1992 male
		DeAndre K. Davis 8-24-1989 male

FRAUD WARNING NOTICES: *(Please review the notice that applies in your state)*

Arkansas/New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky/Ohio: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud. ______________ *(Owner's Initials).*

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Pennsylvania: Any person who knowingly and with intend to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed at (City and State) on (Date): Montgomery AL 6-15-2003	Signature of Proposed Insured age 15 or more
Signature(s) of Additional Insured(s) age 15 or more	Signature of Owner(s) *(if not the Proposed Insured or if Proposed Insured is less than age 18)*
	Signature of Agent: [signature]

Bank Draft Plan

Please attach a void check or deposit slip here in addition to your initial premium.

Max Credit Union
Acct 259662

Bank Draft Plan: EFT Premium Authorization to My Bank

I authorize the payment of debits drawn on my account payable to Fidelity and Guaranty Life Insurance Company, provided there are sufficient funds in said account. I agree that if any such debit be dishonored, Fidelity and Guaranty Life Insurance Company has the right to debit my account the following month for the dishonored debit as well as the scheduled debit for that month. I further agree that if any debit be dishonored, you shall be under no liability in the event the dishonored debit results in the forfeiture of insurance. This authority shall remain in effect until revoked by me in writing and until you actually receive such notice of revocation.

Date	Signature (as it appears on bank records)
6-12-2003	X Bobbie Cleveland

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AUTHORIZED REPRESENTATIVE

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